

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan**POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG-TERM CARE FACILITIES)**RECEIVED
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MCHA-V-J**1. Individual Practitioner Services**

Payment rates are established by the Michigan Department of Social Services as a fee screen for each procedure. The fee schedule is designed to enlist the participation of an adequate number of providers. The Medicare prevailing fees, the Michigan Relative Value Study and other relative value information, other state Medicaid fee screens, and providers' charges are utilized as guidelines or reference in determining the maximum fee screens for individual procedures.

Providers are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. A provider's usual and customary charge should be the fee he most frequently charges his patients with regard to special considerations or financial status.

Annually, the State Legislature appropriates a maximum dollar amount for practitioner services and aggregate payments must not exceed that amount. The State Legislature may also unilaterally increase or decrease fee screens by a specified percentage amount for each fiscal year or part thereof.

The State collaborates with the Michigan Department of Public Health (MDPH) on a Vaccine Replacement Program (VRP). Vaccines are provided free to enrolled Medicaid providers on a replacement basis to immunize Medicaid eligibles. Providers are reimbursed an enhanced administration fee to encourage their participation. The department reimburses the MDPH the government contract price for each dose of vaccine administered, in addition to a per dose handling fee and spoilage allowance. Providers may also request the manufacturer's cost of vaccine if they elect not to participate in the VRP. The department establishes the reimbursement rate for purchased vaccine by allowing the lowest most commonly available cost to purchase the product in multiple dose units plus a nominal administration fee.

2. Drug Products

08/01/95

Payment rates for a drug product are based on the lowest of the upper product limit plus a dispensing fee, the rates regularly charged to the public, or discounts made available by the provider to the public or segment thereof. The upper product limits are determined by the department based on the lowest cost widely available for a drug entity or a group of alternative drugs.

The upper product limits for selected multiple source drugs are known as maximum allowable cost (MAC) limits. Exceptions to the MAC will be allowed as specified by the department. Furthermore, exceptions to the MAC limits must be certified by a practitioner that a covered brand is medically necessary for a particular patient. Such certification must be in the physician's own handwriting, or a check-off box for "DAW", "dispense as written", "brand necessary", etc., are not acceptable certifications. The certification must be retained on file in the pharmacy, available for review by State and Federal auditors.

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3. Michigan Medicaid Maximum Allowable Fee Levels Under OBRA 1989/Section 6402:

Part 1. OBSTETRICAL PRACTITIONER SERVICES

Obstetrical practitioner services means services relating to pregnancy which are covered under the state plan and which are provided by an obstetrician, obstetrical-gynecologist, family practitioner, or certified nurse midwife. They do not include inpatient hospital services or other institutional services.

Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
MATERNITY CARE AND DELIVERY			
59000	\$52.85	\$53.16	Amniocentesis, any method
59010	Deleted from use on 03-31-90		Amnioscopy
59011	Deleted from use on 03-31-90		Amnioscopy (intraovular)
59012	131.97	136.77	Cordocentesis (intrauterine), any method
59015	93.10	94.99	Chronic villus sampling any method
59020	46.08	46.17	Fetal oxytocin stress test
59025	27.55	27.74	Fetal non-stress test
59030	79.87	81.48	Fetal scalp blood sampling;
59031	Deleted from use on 03-31-90		repeat

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Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
59050	63.81	63.81	Initiation and/or supervision of internal fetal monitoring during labor by consultant with report (separate procedure): supervision & interpretation
59051	Added effective 04-01-95	32.98	interpretation only
59100	307.00	0.01^	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion);
59101	Deleted from use on 03-31-90		with tubal ligation
59105	Deleted from use on 03-31-90		Hysterotomy, abdominal, for legal abortion
59106	Deleted from use on 03-31-90		with tubal ligation
59120	418.92	429.75	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121	350.30	358.17	Tubal or ovarian, without salpingectomy and/or oophorectomy
59125	Deleted from use on 03-31-90		ovarian, requiring oophorectomy and/or salpingectomy
59126	Deleted from use on 03-31-90		ovarian, requiring oophorectomy and/or salpingectomy

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Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
59130	358.00	358.17	abdominal pregnancy
59135	***	465.51	interstitia, uterine pregnancy requiring total hysterectomy
59136	Non-covered by Medicaid		interstitial, uterine pregnancy with partial resection of uterus
59140	273.00	273.30	cervical with evacuation
59150	236.80	259.57	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
59151	348.73	352.50	with salpingectomy and/or oophorectomy
59160	150.78	153.51	Curettage, postpartum (separate procedure)
59200	32.50	34.34	Insertion of cervical dilator (e.g. laminaria) (Separate procedure)
59300	73.15	76.73	Episiotomy or vaginal repair only by other than attending physician
59305	Deleted from use on 03-31-90		extensive
59320	129.84	129.96	Cerclage of cervix during pregnancy, vaginal
59325	***	154.81	abdominal

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59350	259.00	259.42	Hysterorrhaphy of ruptured uterus;
59351	Deleted from use on 03-31-90		following dilation and curettage, including both procedures
59400	*Non-covered by Medicaid		Routine obstetric care including antepartum vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	492.38	500.00	Vaginal delivery only (with or without episiotomy, forceps);
59410	496.82	540.00	including postpartum care
59412	67.42	01/70.23	External cephalic version with or without tocolysis (list in addition to code(s) for delivery)
59414	83.84	84.32	Delivery of placenta (separate procedure)
59420	358.78	(deleted from use on 03-31-93)	Antepartum care only (separate procedure)
59425	***	200.00	Antepartum Care only; 4-6 visits
59426	***	435.00	Antepartum Care only, 7 or more visits
59430	20.83	21.00	Postpartum care only (separate procedure)

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59500	Deleted from use on 03-31-90		Cesarean section, low cervical, including in-hospital postpartum care (separate procedure)
59501	Deleted from use on 03-31-90		including antepartum and postpartum care
59510	*Non-covered by Medicaid		Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	458.83	500.00	Cesarean delivery only
59515	526.28	540.00	Cesarean delivery only including postpartum care
59520	Deleted from use on 03-31-90		Cesarean section, classic, including in- hospital postpartum care (separate procedure)
59521	Deleted from use on 03-31-90		including antepartum and postpartum care
59525	249.20	256.66	Subtotal or total hysterectomy after cesarean delivery
59540	Deleted from use on 03-31-90		Cesarean section, extraperitoneal, including in-hospital postpartum care; (separate procedure)
59541	Deleted from use on 03-31-90		including antepartum and postpartum care

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Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
59560	Deleted from use on 03-31-90		Cesarean section with hysterectomy, subtotal, including in-hospital postpartum care; (separate procedure)
59561	Deleted from use on 03-31-90		including antepartum and postpartum care
59580	Deleted from use on 03-31-90		Cesarean section with hysterectomy, total, including in-hospital postpartum care; (separate procedure)
59581	Deleted from use on 03-31-90		including antepartum and postpartum care
X4850	534.31	540.00	VBAC delivery
X4852	419.63	435.00 deleted from use on 02-28-94	Antepartum care only (separate procedure)
X4853	35.94	36.25	Antepartum care only; per visit
X4854	528.96	545.00	Antepartum care only, high risk pregnancy; total care
X4855	44.95	45.40	Antepartum care only, high risk pregnancy; per visit

ABORTION

59800	Deleted from use on 03-31-90		Treatment of spontaneous abortion, first trimester; completed medically
59801	Deleted from use on 03-31-90		completed surgically (separate procedure)

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Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
59810	Deleted from use on 03-31-90		Treatment of spontaneous abortion, second trimester, completed medically or surgically
59811	Deleted from use on 03-31-90		completed surgically (separate procedure)
59812	161.52	163.69	Treatment of spontaneous abortion, any trimester; completed surgically
59820	186.15	189.34	Treatment of missed abortion, completed surgically; first trimester
59821	163.85	163.85	second trimester
59830	194.33	0.01^	Treatment of septic abortion, completed surgically
59840	165.40	0.01^	Induced abortion by dilation and curettage
59841	158.33	0.01^	Induced abortion, by dilation and curettage ^{evacuation}
59850	55.93	0.01^	Induced abortion, by one or more intraamniotic injections per Jim Kline on 4/2/96 KJL
59851	***	0.01^	with dilation and curettage and/or evacuation
•59852	***	0.01^	with hysterotomy (failed intro-amniotic injection)

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Procedure Code	Average Amt. Paid 2nd Previous Year (1994)	07-01-96 Screen	Terminology
59855	Added effective 04-01-95	0.01^	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856	Added effective 04-01-95	0.01^	with dilation and curettage and/or evacuation
59857	Added effective 04-01-95	0.01^	with hysterotomy (filed medical evacuation)
59870	204.80	204.82	Uterine evacuation and curretage for hydatdiform mole
59899	86.11	0.01	Unlisted procedure, maternity care and delivery
76805	77.18	77.79	Echography, pregnant uterus, B-scan and/or real time with image documentation; complete
76815	51.19	51.99	Limited (gestation age, heart beat, placental location, fetal position, or emergency in the delivery room)
76816	42.48	42.87	Follow-up or repeat
76818	56.71	58.39	Fetal biophysical profile

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76825	65.57	65.57	Echography, fetal, real time with image documentation (2D) with or without M-Mode recording
76855	***	35.07	Echography; pelvic area (Doppler)
IMMUNIZATION INJECTIONS			
90700/8	17.47	18.59	Immunization, active; Diphtheria, tetanus toxoids and acellar pertusis vaccine (DTaP)
90700/9	6.99	7.00	
90701/8	13.76	14.78	diphtheria, and tetanus toxoids (DT) and pertussis vaccine (DTP) <i>per Jim McPhearson on 4/3/96 UBS</i>
90701/9	4.71	7.00	
90702	4.10	0.01^	diphtheria, and tetanus toxoids (DT)
90703	4.09	4.11	tetanus toxoid
90704	17.55	0.01^	mumps virus vaccine, live
90705	15.39	0.01^	measles virus vaccine, live, attenuated
90706	17.16	0.01^	rubella virus vaccine, live
90707/8	28.87	32.06	measles, mumps and rubella virus vaccine, live
90707/9	6.73	7.00	
90708	19.83	0.01^	measles and rubella virus vaccine, live
90709	18.06	0.01^	rubella and mumps virus vaccine, live

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